

# SACRAMENTO CENTER FOR HEMATOLOGY AND MEDICAL ONCOLOGY

## CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS

WITH THE INCREASING AWARENESS OF A PATIENT'S RIGHT TO CONFIDENTIALITY, WE ARE ASKING ALL OF OUR PATIENTS TO COMPLETE THIS FORM. IT WILL GIVE THE DOCTORS AND STAFF GUIDANCE AS TO WHO SHOULD BE ALLOWED TO RECEIVE VERBAL INFORMATION ABOUT YOUR HEALTH CARE. PLEASE COMPLETE ONE OF THE 3 OPTIONS LISTED.

1.  DO NOT DISCUSS MY MEDICAL CONDITION WITH ANYONE. *IF YOU CHOOSE THIS OPTION, STOP HERE THEN SIGN AND DATE AT THE BOTTOM.*
  
2.  NO RESTRICTIONS (MAY DISCUSS WITH ANYONE). *IF YOU CHOOSE THIS OPTION, STOP HERE, THEN SIGN AND DATE AT THE BOTTOM.*
  
3.  I, \_\_\_\_\_, GIVE THE PHYSICIANS AND OFFICE STAFF OF SACRAMENTO CENTER FOR HEMATOLOGY AND MEDICAL ONCOLOGY, PERMISSION TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING INDIVIDUALS:

WITH: \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

**THIS CONSENT IS IN FORCE INDEFINITELY UNLESS YOU FILL IN AN EXPIRATION DATE OR YOU REVOKE THIS CONSENT IN WRITING.**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
SIGNATURE DATE

CONSENT EXPIRATION DATE (If any) \_\_\_\_\_